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National Update on Therapeutic Community Programs for Substance Abusing Offenders in State Prisons

by Peter B. Rockholz

During the past five years, the therapeutic community (TC) has re-emerged as a preferred, effective methodology for reducing both relapse to drug abuse and recidivism to the criminal justice system among substance abusing offenders. The "community as method" concept—a hallmark of the TC process—is identified as the key defining distinction between TC programs and other types of prison-based residential substance abuse treatment programs. Encouraged by several national evaluative research studies of in-prison TC programs, and supported through funding under the federal Residential Substance Abuse Treatment (RSAT) program, the majority of state correctional agencies have chosen to implement TC programs in their prisons. This article reports the results of a national survey of TC programs in state prisons conducted by the Association of State Correctional Administrators (ASCA), and findings of field testing of national prison TC standards conducted by the Criminal Justice Institute, Inc. (CJI) and then identifies critical issues related to implementing TC programs and other types of residential treatment

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A Statewide Integrated Quality Assurance Model for Correctional-Based Therapeutic Community Programs

by David Kressel, Diane Zompa, and George De Leon

In recent years federal and state initiatives have dramatically increased support for treatment of substance abuse problems within the correctional system. This reflects two related developments, the increasing proportion of prison populations serving time for drug specific and drug-related crimes, and the accumulating evidence supporting the effectiveness of prison-based treatment, particularly modified therapeutic communities (TCs), in reducing drug-related crime (Field, 1989; Inciardi, et al., 1997; Knight, et al., 1997; Prendergast et al., 1996; Wexler, et al., 1992, 1999).

The federal response to these developments has been to provide funding for expanding capacity for residential substance abuse treatment for state prisoners. Parallel support for treatment in corrections has been evident in many state initiatives. Notwithstanding these important initiatives, the rapid expansion of correctional-based TC treatment has underscored problems critical to policy and practice. These center on the general theme of the fidelity of treatment and its relation to treatment effectiveness. Variability in treatment programs, particularly with respect to the fidelity of the TC approach, clouds conclusions concerning the effectiveness of TC treatment in correctional settings.

Under the vision and leadership of the Commissioner of the New Jersey Department of Corrections (NJDOC), we developed and conducted a pilot project demonstrating the feasibility of a Statewide Integrated Quality Assurance Model (SIQAM) for correctional-based TC programs. The model is designed to improve and maintain high quality TC treatment. The goal is to enhance public safety by increasing security in the institution and decreasing the likelihood of relapse and recidivism after release.

Overview of TC Approach

Traditional, long-term residential TCs are similar in planned duration of stay (nine to 24 months), structure, staffing pattern, perspective, and rehabilitative regime, although they differ in size (30 to several hundred beds) and client demography. Staff consists of TC-trained clinicians and other human service professionals. Primary clinical staff are often former substance abusers who themselves were rehabilitated in TC programs. Other staff include professionals who provide medical, mental health, vocational, educational, family counseling, fiscal, administrative, and legal services.

TCs accommodate a broad spectrum of drug abusers. Although they originally attracted narcotic addicts, a majority of their client populations are non-opioid abusers. Thus, this modality has responded to the changing

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in prisons and poses challenges faced by emerging national prison TC standards in distinguishing TCs from other prison-based programs.

National Survey Findings

During July 2000, ASCA conducted a survey to inventory and obtain basic information about prison TCs in North America. Completed surveys were received from all 50 states, the Federal Bureau of Prisons (BOP), New York City, the City of Philadelphia, Puerto Rico, and Canada. Preliminary results are presented below, along with a discussion of implementation and process issues.

Extent of TC Programming. As illustrated in Table 1, the survey identified 252 prison TC programs in 40 states and three non-state jurisdictions (Canada, New York City, and Philadelphia). Four additional states indicated they plan to implement TCs by the end of 2002; the resultant total of 44 states anticipate adding 38 more TCs, bringing the total to 289 by the end of year 2002. Only Arizona, Montana, North Dakota, and the BOP reported having neither TCs nor plans to develop TCs in the next year. Four states (California, 37; New York, 25; Texas; 25; Florida, 15) account for over one-third (37%) of the existing TCs.

The substantial expansion of prison TCs across the nation resulted in a rapid depletion of experienced TC practitioners.

As illustrated in Figure 1, the greatest period of new program start-ups has been during the past four years; 41.8% of existing programs opened since 1997, with a peak of 51 programs starting in 1999. Newer programs tend to be relatively smaller than those already in operation. For example, the planned, new programs are 38% smaller on average compared to existing programs (i.e., mean capacity of 95 versus 154).

Inmates Served. Individual institutions report their TC programs ranging in capacity from 15 to 1,000 participants, with a mean of 154 (median=100). Three-fourths (73.9%) of the TC programs serve only men, 22.5% serve only women, and 3.6% report serving both. About half (48.4%) of the programs had an inmate capacity below 100; 20% were over 200. The total reported inmate capacity of existing prison TC programs in the United States is 40,362 (four facilities not reporting). With planned expansion, this figure is projected to exceed 44,000 by the end of 2002. Actual one-day census reports suggested an average TC bed utilization of 95.2% (41 facilities not reporting). Program census figures ranged from 13 to 1,000 with a mean of 142 (median=85). During 1999, it was reported that 31,493 inmates successfully completed TC programs.

All programs specified substance abuse as a primary participant characteristic. All custody levels are represented. Six programs are exclusively for youthful offenders, five for sex offenders, and four for those with co-occurring psychiatric disorders. Other special population programs include those specifically designed for pre-release, chronic relapsers, parole violators, chronic DUI offenders, batterers, and violent and aggressive inmates.

Staffing. A majority (58.7%) of TC programs are operated by private providers under contract, with the remainder run by public employees of either the state correctional agency or the Single State Agency (SSA) for alcohol and drug abuse services. The existing programs (19 facilities

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Table 1 – Prison TC Programs in the United States

State/Juris.	# TCs	% Private	Male Cap.	Female Cap.	Total Cap.
AL	2	0%	224	0	224
AK	1	100%	0	48	48
AZ	0				
CA	27	100%	4,562	1,952	6,514
CAN	3	34%	90	0	88
CO	6	83%	372	72	444
CT	4	0%	220	60	280
DE	10	100%	1,016	126	1,142
BOP	0				
FL	15	100%	3,175	172	3,347
GA	4	100%	68	48	116
HI	4	0%	272	15	293
ID	2	100%	86	0	86
IN	2	100%	194	72	266
KS	4	100%	284	30	314
LA	5	0%	316	50	366
ME	1	100%	40	0	40
MD	1	0%	550	0	550
MA	10	100%	418	75	493
MI	3	100%	408	60	468
MN	2	0%	96	0	96
MS	1	0%	396	0	396
MO	4	75%	1,331	90	1,421
MT	0				
NE	3	0%	162	19	181
NV	1	100%	106	0	106
NJ	7	100%	1,211	60	1,271
NM	6	34%	482	80	562
NY	26	4%	4,546	629	5,175
NYC	2	100%	702	200	902
NC	0				
ND	0				
OH	5	60%	480	81	561
OK	9	78%	573	102	875
OR	3	100%	150	60	210
PA	8	25%	552	102	657
PHL	5	100%	322	100	422
RI	4	100%	122	28	150
SC	4	75%	656	132	788
TN	8	38%	263	128	391
TX	25	40%	6,636	1,612	8,248
UT	5	0%	287	126	413
VT	2	100%	109	0	109
VA	9	0%	1,364	461	1,825
WA	2	100%	100	100	200
WV	4	0%	187	36	223
WI	1	0%	45	0	45
WY	2	100%	28	28	56
Totals	**252**	**59.2%**	**33,201**	**6,954**	**40,362**

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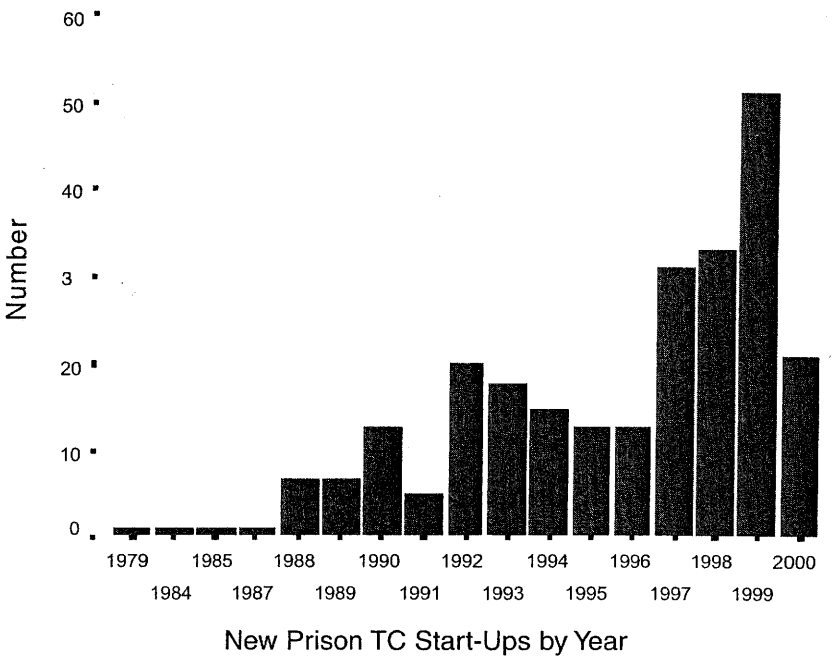
not reporting) employ 2,701 staff, with an average (mean) per program of 11.5 (median=7). The mean number of participants per staff member is 15.4

TC, or Not TC?

Some Confusion About What a TC Is. While state officials were asked in the survey to respond only about prison programs that they identified as TCs, the responses raise questions—and will likely rekindle debate—about what constitutes a "real" TC versus a residential program with some TC-like components. Certainly, many of the programs reflected in the results of the survey only vaguely resemble what is understood by TC experts to constitute a "real" TC. In fact, many programs operate with a traditional medical model approach, utilizing combinations of the 12-step programs and various curriculum-driven, cognitive-behavioral, psycho-educational training and other therapies. While many of these programs borrow some of the identifiable structures of TCs (e.g., morning meeting, structure board, written philosophy), they often lack those core processes that are at the essence of what De Leon (1997) describes as the "community as method" approach of the traditional, including what are known as "modified," TC programs. It was that approach, along with practical experience and De Leon's theoretical framework, that shaped the author's original draft of prison TC standards that were initially field tested in the Ohio prison system in 1993, and formed the basis for the first version of the Therapeutic Communities of America (TCA) draft standards.

Standards Development. The current initiative to develop national prison TC standards—now a joint project between TCA and the American Correctional Association (ACA)—is, in part, an attempt to identify essential elements of TCs (necessarily modified for prison settings) toward offering accreditation for these programs. The TCA/ACA accreditation process must reliably distinguish between nominal TCs and "real" TCs. Unless the TCA/ACA initiative requires compliance with a small number of essential standards that truly reflect the "heart and soul" of the TC, it is unlikely that the accreditation process will accomplish this distinction. In an effort to identify essential, defining TC standards, and to propose modifications to the TCA/ACA accreditation process in development, CJI has identified 10 critical standards (nine of which are directly excerpted from the TCA draft), and developed observable indicators for each of them for consideration of the authors of the accreditation standards (see Table 2, next page).

Figure 1: Frequency Distribution of Prison TC Program Starts by Year of Opening



Field Review Observations. CJI has conducted formal and informal reviews of prison TC programs in six states using the TCA-developed draft standards along with CJI's critical standards instrument. In three of those states, all existing TC programs across the state were reviewed. In general, a clear concern was raised about the probability that several programs, purported by state officials and program operators to be TCs, would likely pass the national prison TC standards (assuming a minimum compliance rate in the range of 80%-85%) without meeting the core standards that distinguish TCs from other types of residential programming. In some cases, program operators could argue convincingly that they complied with several standards, and might potentially "pass" others depending upon the background and philosophy of the individual reviewer(s). Unless the accreditation process requires compliance with those standards that most clearly differentiate TC programs from others, programs with little resemblance to the traditional TC "community as method" approach might be able to achieve accreditation as TC programs.

Critical TC Factors

Several process factors, set out below, must be considered when determining whether prison TC programs meet the definition and intent of "real" TC programs.

Staffing. The substantial expansion of prison TCs across the nation resulted in a rapid depletion of experienced TC practitioners, particularly those who have participated in a TC themselves, available to manage and staff the new prison TCs. While it is desirable, as noted in the national standards, to have a reasonable mixture of "professionally trained" clinicians and "TC naturalists" (i.e., those who have graduated from TC programs), low supply and high demand have prevented this in several states. There are not enough ex-addict, ex-offender staff (e.g., TC graduates) to meet the national demand. Compounding this are policies in several states that prohibit ex-offenders from working in prisons in any capacity. Additionally, in an effort to ensure staff competency, many states require TC staff to have college degrees and/or chemical dependency counselor certification or licensing. While this has the effect of improving the professionalism of treatment planning and other functions, it does not necessarily enhance TC processes and further reduces the pool of eligible TC naturalists. In fact, in the author's experience,

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Table 2: Criminal Justice Institute Critical Standards and Observable Key Indicators for Prison TC Programs

Critical Standard*	Key Indicators
1. The primary approach to treatment is "community-as-method." [CP1]	• Observers sense that there is a pervasive attitude of "we are all in this together" rather than a traditional "patient-therapist" or individual focus and approach. • Observers feel that there is a meaningful involvement and relationship between program participants rather than a collection of individuals primarily focused on their own personal issues.
2. Treatment activities emphasize experiential learning (direct and vicarious)—"doing" rather than "getting" therapy. [CP5]	• Clinical interventions and learning experiences place participants in roles and situations that achieve social learning—rather than focusing on individual, cognitive solutions. • Group dynamics are utilized to give participants direct feedback on the effects of their behavior and attitudes on other participants and the community as a whole.
3. Negative behaviors and attitudes are confronted immediately and directly by peers, and this practice is seen as acceptable by the community, is reinforced by it, and acts to neutralize prison culture attitudes. [CM6]	• "Pull-ups" (i.e., verbal, awareness raising comments) between program participants occur "on the floor" frequently, and with a feeling of genuine commitment. • Obvious inappropriate behaviors and attitudes are not let go by residents within the area.
4. There are clearly defined privileges—e.g., status advancement, more desirable living space—that are earned based upon clinical progress. [CM4]	• Promotion is based upon achievement of personal growth rather than on time or completion of prescribed activities or curriculum. • There is a sense that participants are genuinely motivated to strive for advancement and that the privileges are meaningful and reinforcing of positive actions.
5. A major focus of participant learning is on the development of affective skills, including the ability to identify and express feelings in a pro-social manner. [CP8]	• Participants strive to keep each other focused on their feelings, on the "here and now", "gut level", and on connecting current behavior with feeling states, rather than supporting intellectualization and other ego defenses. • There is evidence that painful emotions are openly shared and freely expressed (e.g., tears, etc.) and that the environment provides safety and sanctuary for this to occur.
6. There is a clear sense of cooperation between clinical and security staff and residents, rather than an authority-based, oppositional relationship ("we-they dichotomy").	• Participants assume responsibility for unit compliance with expectations of security, resulting in minimal need for correctional officers to give directions. • Staff/participant interactions demonstrate respect in both directions.
7. Participants perform all possible house chores, e.g., cleaning, maintenance, clerical, expediting, etc. [TC2]	• To the greatest extent possible, participants exhibit both "pride and quality" and ownership in their community and its environment. • The apparent attitude of participants is that their job functions are meaningful and support the positive functioning of the community, rather than simply being busy work.
8. Participants are encouraged to "act as if" as a means of developing a positive attitude. [TP9]	• Senior participants actively seek to help junior participants become fully engaged in the TC process. • Senior participants demonstrate positive qualities of "right living" as a way to encourage others to strive toward their role modeling.
9. Peer feedback occurs more frequently than staff counseling. [TP6]	• There is continuous evidence that participants actively seek to provide positive counsel and support to each other. • Group sessions are dominated by peer interactions rather than by staff providing individual counsel and information.
10. The program uses groups as a primary clinical intervention, including encounters, probes, marathons, tutorials, etc. [TC5]	• Interactive groups are utilized several times per week to address current behavioral and attitudinal issues between participants. • The primary mode of group therapy is encounter, rather than discussion or psycho-educational sessions.

* Selected from *Revised TCA Standards for TCs in Correctional Settings*, prepared for the Office of National Drug Control Policy (ONDCP) by the Criminal Justice Committee of Therapeutic Communities of America (TCA), November 1, 1999.

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greater reliance on academic degrees and professional certification than on TC experience results in lessened potency of the core clinical TC processes.

Quality Assurance. In an effort to ensure high quality of services and cost-effectiveness (particularly where TC program services are contracted for with private providers) several states require that prison TCs be licensed as substance abuse treatment programs by a state agency. As with the paradoxical impact of counselor credential requirements, this has been observed in several cases, unfortunate-

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Table 3 – Comparison Between Basic TC and Traditional Medical Model Paradigms

TC Model	Medical Model
Views addiction as one of many secondary problems, and views the whole person as the problem	Views addiction as a primary disease, and as the central problem to be addressed in treatment
Treatment utilizes a behavioral approach	Treatment utilizes disease management approach
Program participants viewed as community or family "members"	Program participants viewed as "clients" or "patients"
Community process is primary therapeutic agent and occurs 24 hours/7 days a week	Treatment is therapist-directed (i.e., doctor-patient) and often manual-driven, occurring during sessions
Psycho-educational and didactic groups are seen as tools to support the TC process	Psycho-educational and didactic group and individual methods are the clinical approach—the sessions are the treatment
Effective TCs utilize a mixture of TC graduates, other recovering persons, and trained clinicians as staff	Programs encouraged and/or required to utilize only clinical staff that are certified, degreed, or otherwise credentialed and traditionally trained
Personal issues are public—confidentiality is maintained within the TC group	Personal issues are private—confidentiality is maintained within the client-counselor relationship
Staff role defined as facilitating a mutual self-help, positive peer process	Staff role defined as providing treatment services
Greater emphasis on affective skills development	Greater emphasis on cognitive skills development
Group encounter is primary clinical intervention	Individual counseling is primary clinical intervention
Staff share personal information and are engaged in the community process	Staff maintain professional distance and function outside the milieu process

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ly, to lead to decreased quality and potency of the TC process. It is hoped that the greatly anticipated availability of national standards for prison TCs will enable states to resolve this dilemma by accepting the TCA/ACA standards in lieu of licensing.

Structured Programming. A similar situation has been observed in states where standardization of programming is deemed an important goal and thus required in provider contracts. Program standardization has been observed to result in over-reliance on formal curriculum delivery and an over-reliance on the use of discussion groups, as opposed to an interactive and less predictable group encounter approach. The latter, of course, requires highly trained staff who are intuitively knowledgeable about such attributes of substance-dependent offenders as self-deception and manipulative behavior—especially among those with antisocial personality disorder. Structured programs tend to place greater emphasis on process over outcomes—e.g., participants can complete a curriculum involving written and oral assignments and yet change little of their behavior. Traditional TCs instead emphasize personal growth as judged by peers and staff through behavioral and attitudinal change demonstrated within intensive interpersonal relationships and interactive social learning practices.

Monitoring Oversight. It has been observed that, when state agencies attempt to develop monitoring instruments to measure basic performance of prison TCs they tend to emphasize "low bar" standards (e.g., beds made, shirts tucked in, completion of written assignments). This can result in minimal compliance with the "low bar," while the programs miss the more critical achievement of effective clinical depth.

Treatment Model. While there are many similarities between the medical model and TC approaches, the few differences are monumental in creating the community treatment effect (see Table 3). It is important for programs to examine and carefully integrate these approaches and to help staff resolve their philosophical differences. In some cases, TC methods create both ethical and personal conflicts for traditionally trained chemical dependency counselors.

Conclusion

The TC benefits that are realized by inmates and their families, by society (the reduction of direct and indirect costs to the public), and by correctional agencies (improvement in institutional management) will continue to provide an impetus for the further growth and proliferation of prison TC programs both nationally and internationally. At the same time, it is incumbent upon state agencies to recognize the challenges presented during this rapid period of expansion. For example, the importance of dedicated residential TC aftercare programming for released inmates has been well established through evaluative research (Martin et al., 1999). It is equally important that TC-specific staff competencies be developed and enhanced through qualified, ongoing staff training activities, and that the inclusion on staff of ex-offender/ ex-addict TC naturalists be supported.

National standards hold great promise in assisting prison TC programs. However, standards-writers face the challenge of distinguishing TCs from other residential treatment approaches and therefore supporting the clinical depth necessary to achieve the effectiveness of the first-generation, model prison TCs. The potential danger is that, without continued support and enhancement, these programs may lose their effectiveness and the result will be the incorrect proclamation that "TCs don't work." Finally, especially in those states with few experienced TC practitioners, it is important to engage the assistance of national experts in the design, implementation planning, and development of TC programs in order to ensure their efficacy and longevity. This is an exciting time, as the field of corrections is experiencing an opportunity to significantly reduce recidivism by effectively addressing the problem of substance abuse among offenders.

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Peter B. Rockholz, M.S.S.W., is a Senior Associate with the Criminal Justice Institute, Inc., a member of the editorial board of the Offender Substance Abuse Report, *and a faculty member at the Yale University School of Medicine. He may be contacted by email at PRockholz@cji-inc.com.* ■

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David Kressel, Ph.D., the person to whom all correspondence should be addressed, is Principal Investigator at the Center for Therapeutic Community Research at National Development and Research Institutes, Inc., New York, NY. He may be reached by email at david.kressel@ndri.org. Diane Zompa, Ph.D., is Director, New Jersey Department of Corrections Office of Community and Drug Program Operations, Trenton, NJ. George De Leon, Ph.D., is Director of the Center for Therapeutic Community Research at NDRI. ■

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Civic Research Institute, Inc.
4478 Route 27 P.O. Box 585
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